Building a Foundation for Health Care System Reform in Virginia

COMMONWEALTH OF VIRGINIA

Document for discussion

October, 2006

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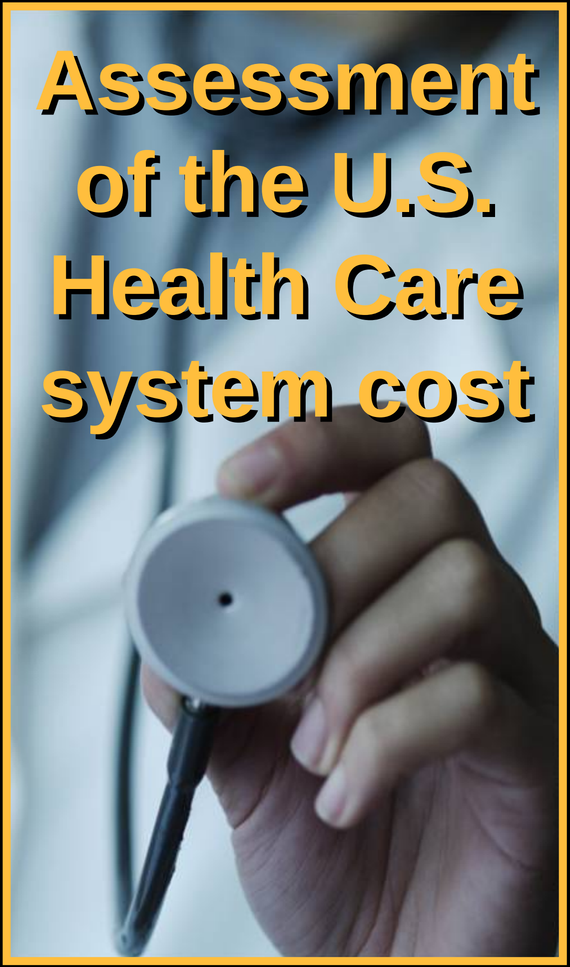
TOPICS FOR TODAY'S DISCUSSION



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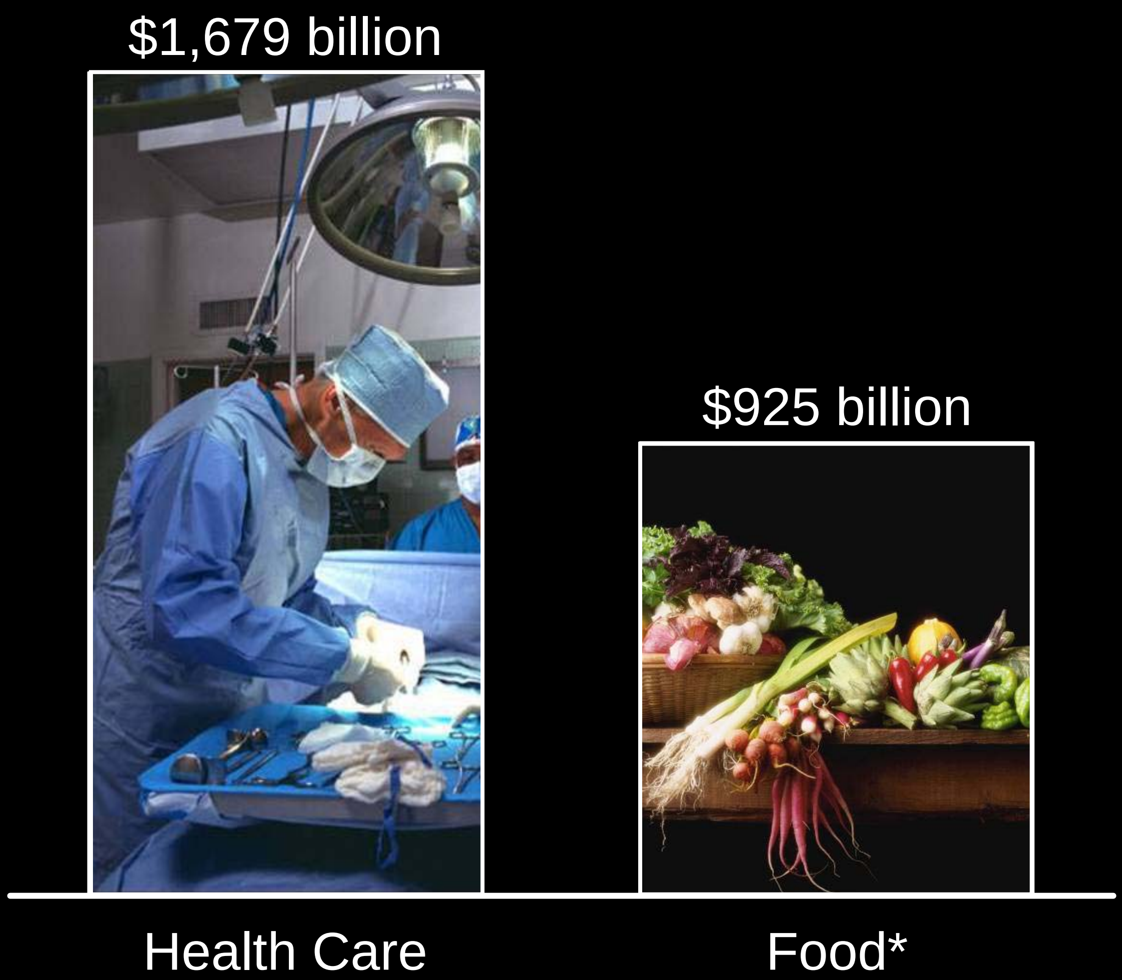
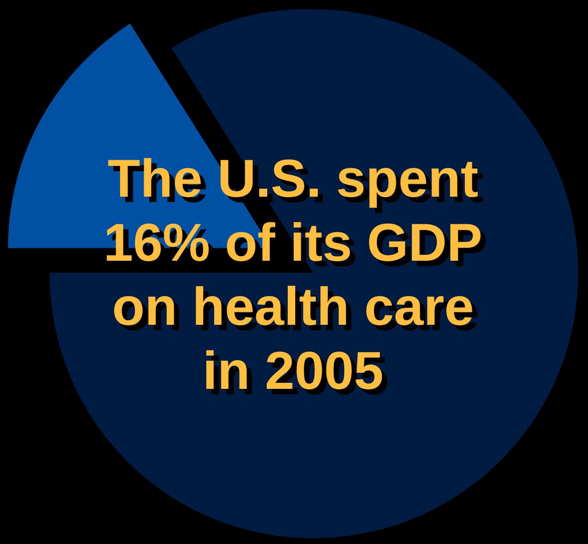
THE UNITED STATES SPENDS MORE MONEY ON HEALTH CARE THAN ON FOOD . . .

2003





* Excludes alcoholic beverages ($121 billion) and tobacco products ($88 billion)

Source: Krugman, Paul and Willin, Robin. The Health care Crisis and what to do about it. The New York Review of Books, V. 53 (5) March 23, 2006 available at http://www.nybooks.com/articles/18802

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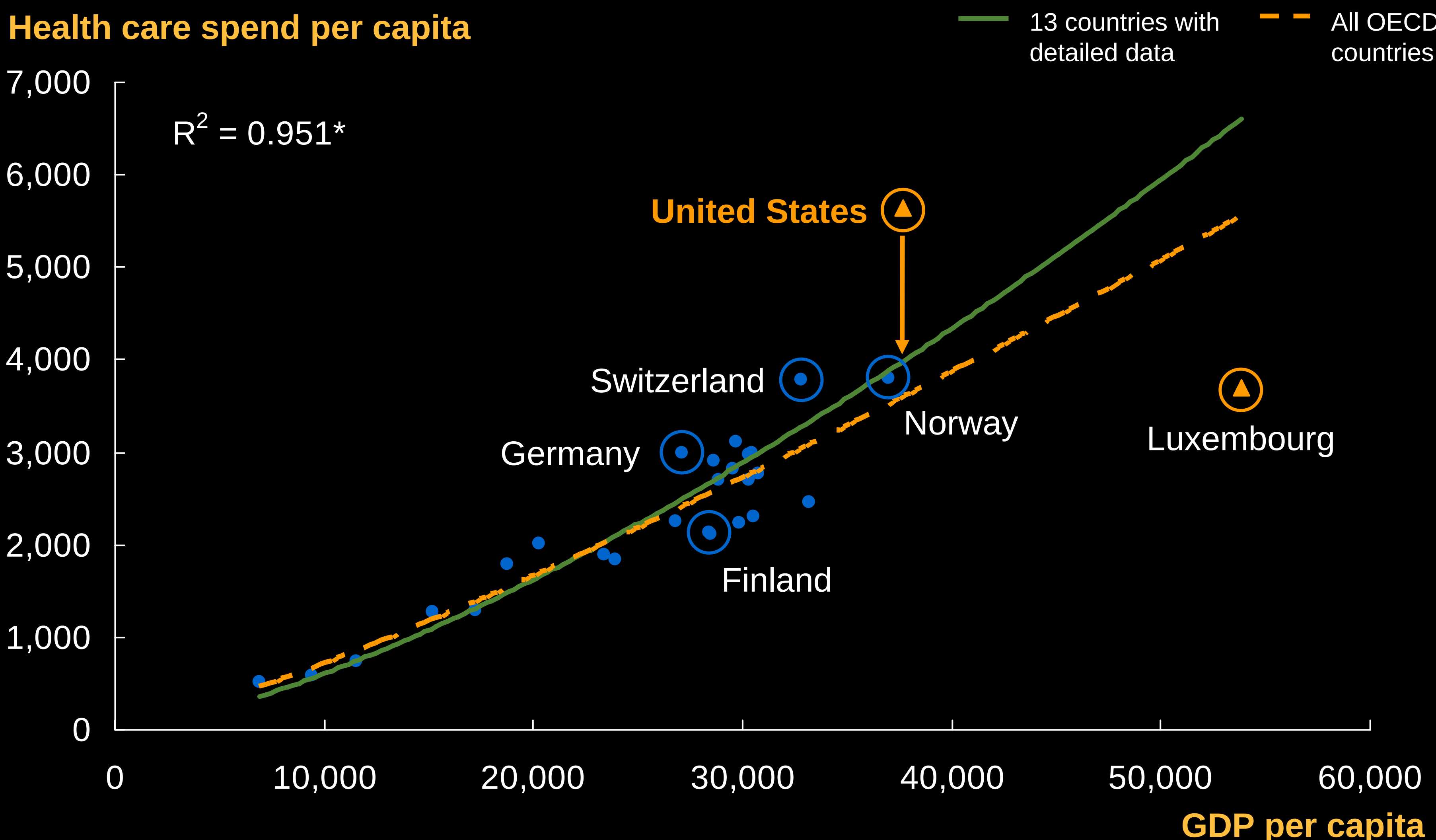
. . . AND FAR MORE PER CAPITA THAN OTHER COUNTRIES

$ PPP, 2003



* Includes OECD countries that report broken-down data; excludes United States

Source: Reinhardt et al. U.S. Health Care spending in an international context. Health Affairs 23 (3): 10. (2004)

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POSSIBLE EXPLANATIONS FOR HIGHER U.S. HEALTH CARE SPENDING

United States has a more costly health care system because . . .

- **U.S. population is less healthy than in other countries**
- Health care system is intrinsically more expensive
  - United States consumes more inputs for the same disease mix
  - Operational processes in the United States consumes are more expensive
  - Intermediaries and government investment result in higher costs to system

Source: MGI analysis

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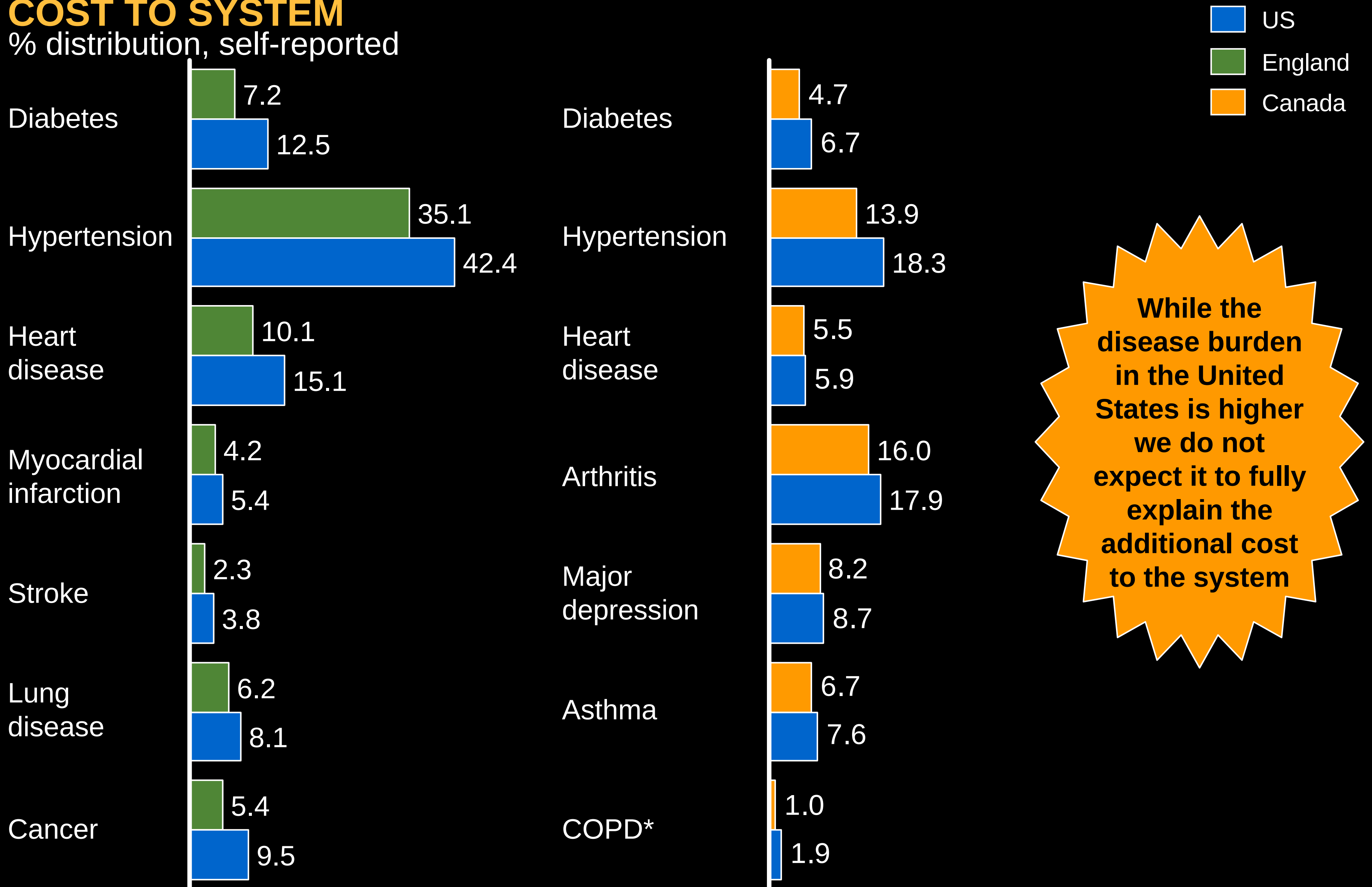
MODESTLY SICKER POPULATION DOES NOT EXPLAIN ADDITIONAL COST TO SYSTEM

% distribution, self-reported



* Chronic Obstructive Pulmonary Disease

Source: Banks, etal (2006) JAMA 295 (17) May 3, 2006 pg 2037 - 2045 ; Lasser et al: Am J Public Health.2006; 0: AJPH.2004.059402v1

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POSSIBLE EXPLANATIONS FOR HIGHER U.S. HEALTH CARE SPENDING

United States has a more costly health care system because . . .

- U.S. population is less healthy than in other countries
- **Health care system is intrinsically more expensive**
  - United States consumes more inputs for the same disease mix
    - Prices are higher for labor, drugs/devices
    - US uses more labor
    - Higher cost of capital to recover
  - Operational processes in the United States consumes are more expensive
    - Large fixed costs / lower utilization
    - Fragmented provider ownership
    - Complex system (payors, payments, regulatory)
  - Intermediaries and government investment result in higher costs to system
    - Public administrative costs higher than peer OECD systems (Medicare and 50 Medicaid programs)
    - Fragmented commercial payor system

Source: MGI analysis

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KEY MESSAGES

Key messages

- U.S. health system incentives are optimized for the participants at the expense of patients/employers
- While U.S. patients may enjoy quality of life, convenience, and other benefits, additional cost relative to other countries is not resulting in longer life expectancy
- U.S. is higher than GDP-adjusted expectations for virtually all parts of the health system
- Ongoing cost growth at current growth rate is likely to hinder greater U.S. economic growth

Reform programs need to consider the following:

- Realigning existing incentives
- Addressing both supply and demand
- Improving quality simultaneously while addressing cost issues
- Withstanding the reactions of existing stakeholders

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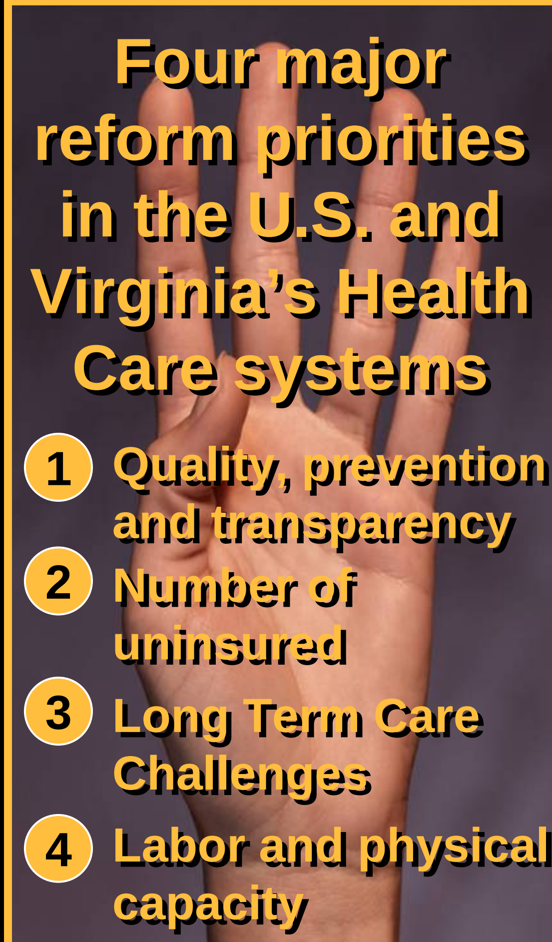
TOPICS FOR TODAY'S DISCUSSION



Four major reform priorities in the U.S. and Virginia's Health Care systems

1. Quality, prevention and transparency
2. Number of uninsured
3. Long Term Care Challenges
4. Labor and physical capacity

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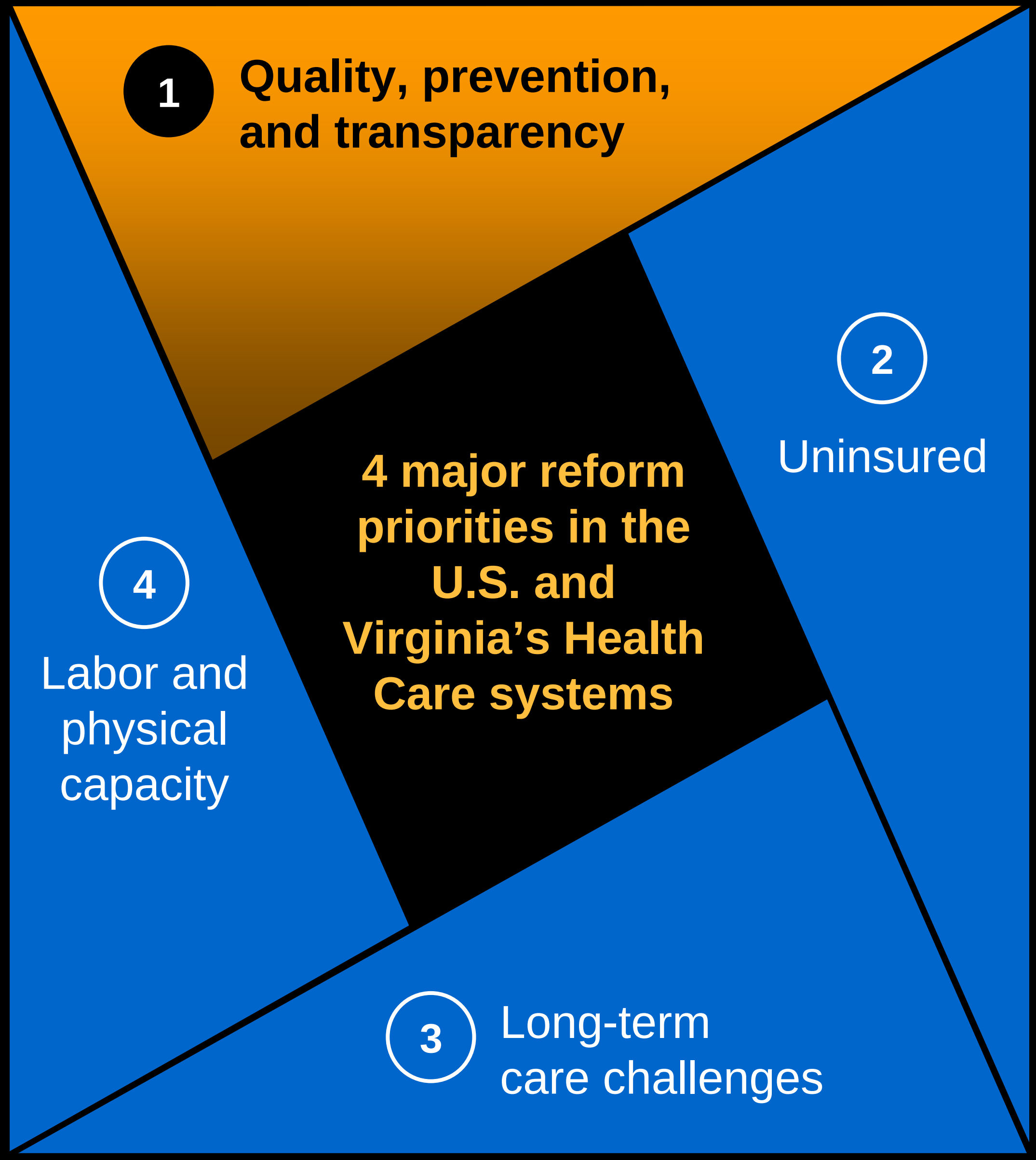
VIRGINIA REFORM PRIORITIES



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1 QUALITY, PREVENTION AND TRANSPARENCY

Main messages for the U.S.

On **Quality and Prevention:**

- The U.S. has a **modestly sicker population** than peer developed countries
- **Life expectancy** is slightly **below OECD average** and **infant mortality higher than in peer countries**
- **Larger number of extremely obese people** (though overall obesity is in line with peer countries)
- **Lower tobacco consumption** than in peer countries (50% reduction in the last 25 years)

On **Transparency:**

- **Limited information available** – rarely able to link data on price, quality, service, hospital, and physician information
- There is **significant price variation** within local markets for the same procedures
- Rapid improvement in quality when transparency and payments are linked

Main messages for Virginia

On **Quality and Prevention:**

- **Virginia lies in the third quartile** in most quality and prevention metrics when compared to the other states

On **Transparency:**

- There's **significant price variation** for the same procedures **within the same county** (15% on average, with some cases as high as 50%)
- Information is available on cardiac outcomes, financial performance, outpatient care from VHI.org and VHQC.org
- Virginia hospital association is **developing a consumer oriented information tool**

Source: Team analysis

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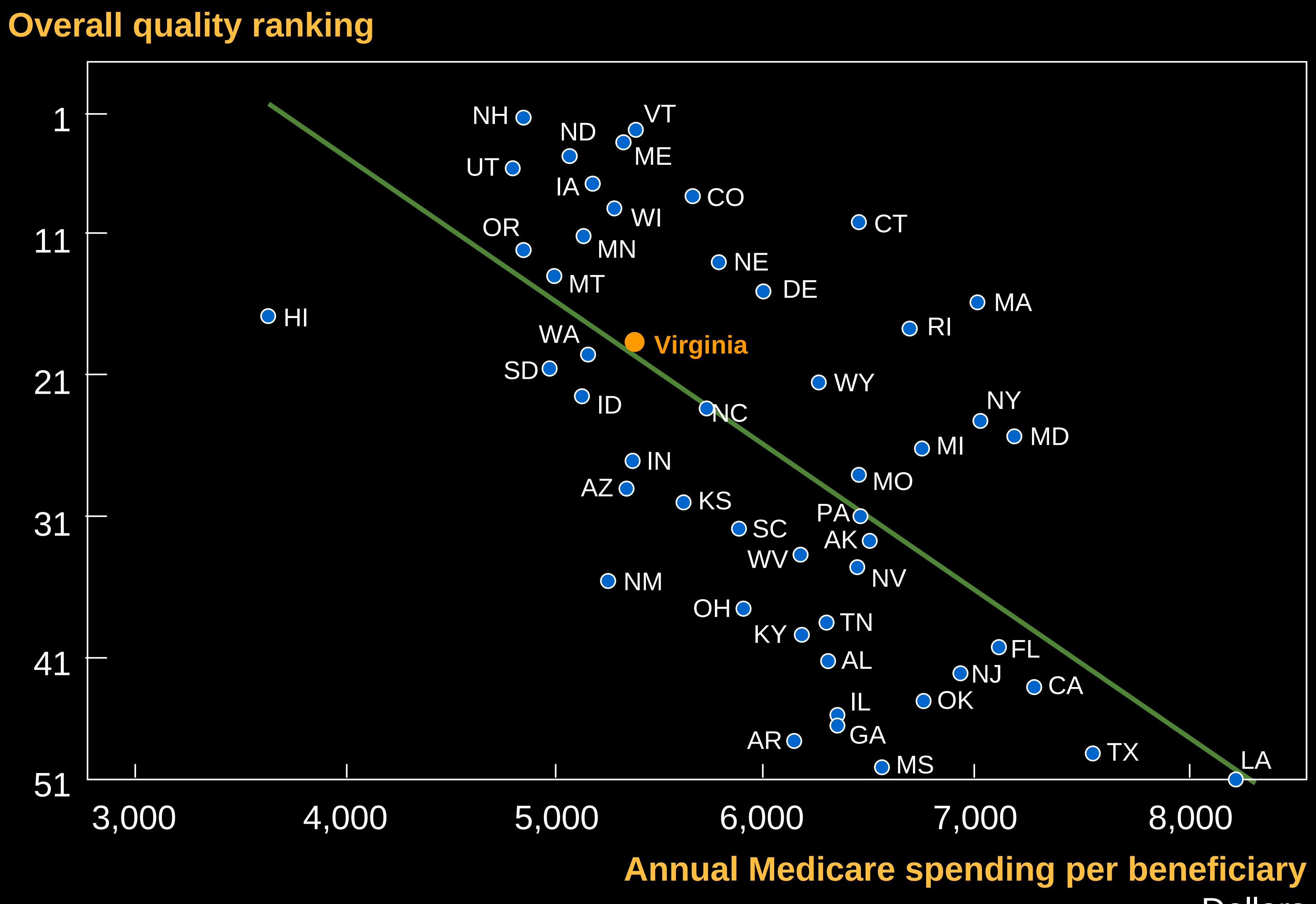
QUALITY IS NOT CORRELATED WITH HIGHER SPENDING

Association between Medicare and quality ranking – US states



Source: Baicker and Chandra; Health Affairs; Web exclusives

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1 THE WHITE HOUSE HAS ACCELERATED EXISTING EFFORTS TO INTRODUCE INFORMATION TRANSPARENCY

Intent behind transparency

Design options being considered

Source: HHS release

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1 EXAMPLES OF PRICING INFORMATION IN THE MARKET TODAY

Key players	Number of procedures	Number of hospitals	Number of doctors	Geography covered	Physician-specific pricing	Display balance after insurance
Aetna	25 (physician services) and 600 procedures. 8/06 – selected in pt.	Unknown	70,000	Portions of CT, DC, VA, MD, KY, IN, FL, OH, MO, KS, NV, PA	Yes as of August	No – patient liability dependent on policy structure
UnitedHealth Group	150	Unknown	Unknown	100 markets (nationwide)	Unknown	No – patient liability dependent on policy structure
HUMANA	36 hospital services (30 inpatient, 6 outpatient)	TBD – most Wisconsin hospitals	Unknown	Southeast Wisconsin (offered to 30 businesses)	Unknown	No – patient liability dependent on policy structure
HealthMarkets	20,000	4,000	437,000	Nationwide	Yes	Yes
CMS Centers for Medicare & Medicaid Services	30 elective non-surgical	All	Unknown	All states	TBD	No
CIGNA	Quality for 168 Cost for 53 (29 in-patient, 16 outpatient surgical, 8 adv. radiology); will expand in Jan '07	All (including those not in CIGNA network)	Physician Quality and Cost Effi-ciency tool launching Jan 2007	Nationwide	Launching Jan. 2007	No – patient liability dependent on policy structure
WellPoint	40	TBD – most Dayton hospitals	Unknown	Dayton, Ohio (for General Motors)	Unknown	No – patient liability dependent on policy structure

Source: Press releases, interviews

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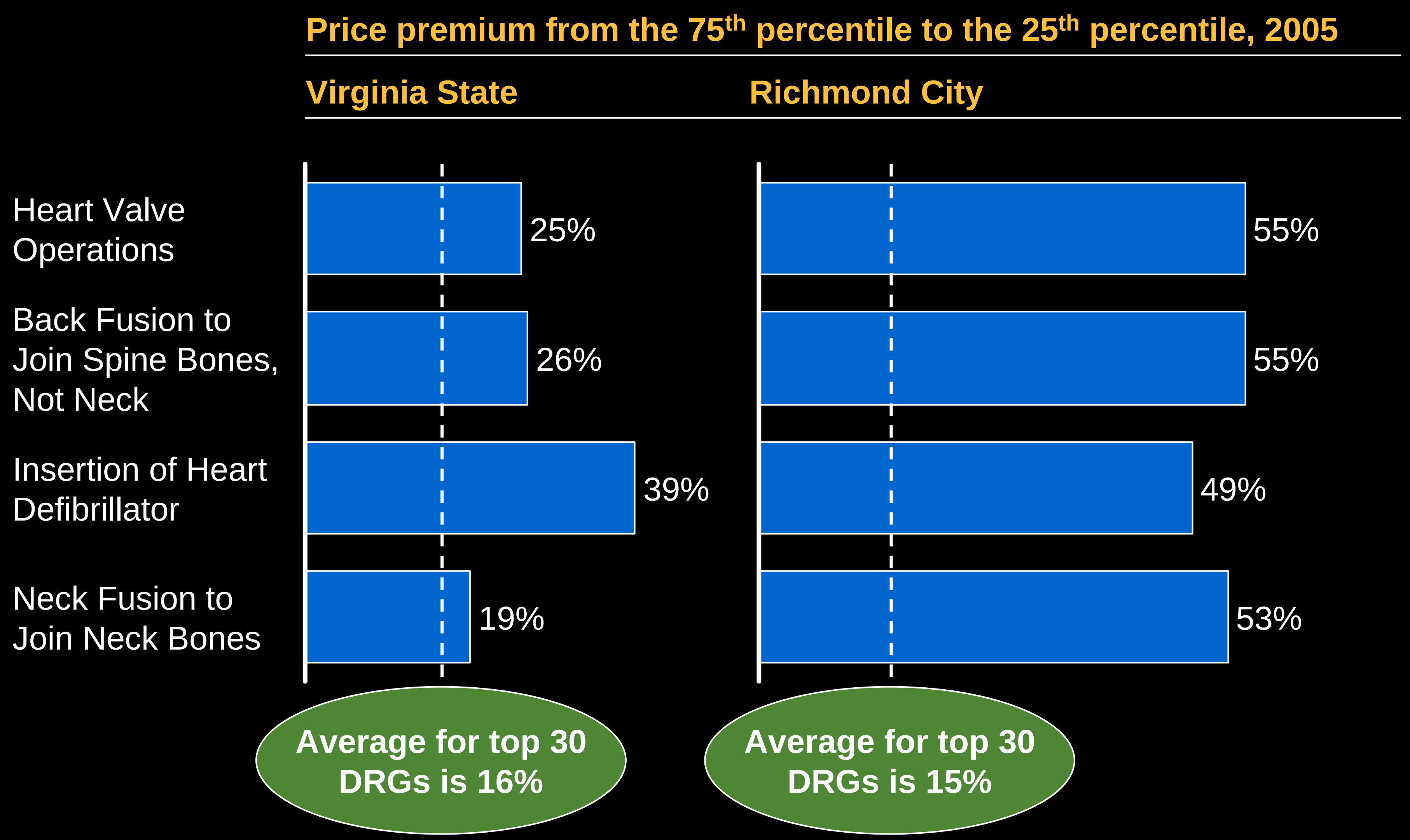
1 EXAMPLES OF PRICE VARIATION WITHIN VIRGINIA AND RICHMOND CITY FOR TOP DRGs



Source: MedPAR; team analysis

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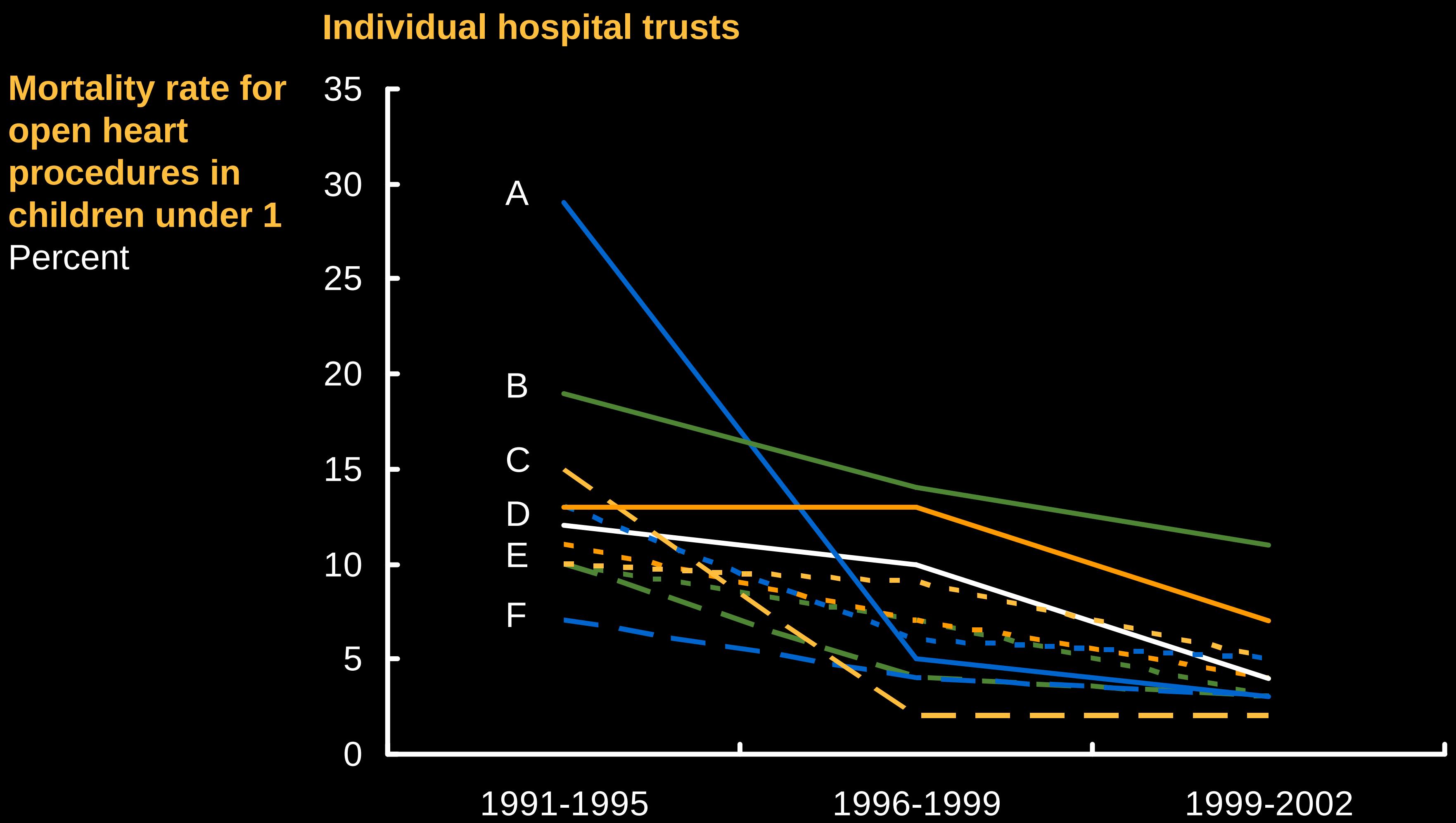
QUALITY TRANSPARENCY CAN IMPROVE OUTCOMES AND DIMINISH VARIATION: UK EXPERIENCE

Reduction in mortality rates since data began to be published by a private company



Source: Aylin et al. British Medical Journal, October 2004

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1 CMS IS STARTING TO SET PERFORMANCE STANDARDS AROUND QUALITY AND TRANSPARENCY

CMS-Premier Pay-for-Performance Demonstration Project, initial year results

Payment adjustments (based on quality measures performance) can result in 25-35% difference in profit

Composite quality index scores

	Baseline	1-year follow-up	Percent improvement*
AMI	90%	93%	30%
Heart failure	64%	75%	31%
Pneumonia	70%	80%	33%
CABG	86%	90%	29%
Hip and knee replacement	85%	91%	40%

* Assumes goal of 100% compliance for each metric

Source: Team analysis

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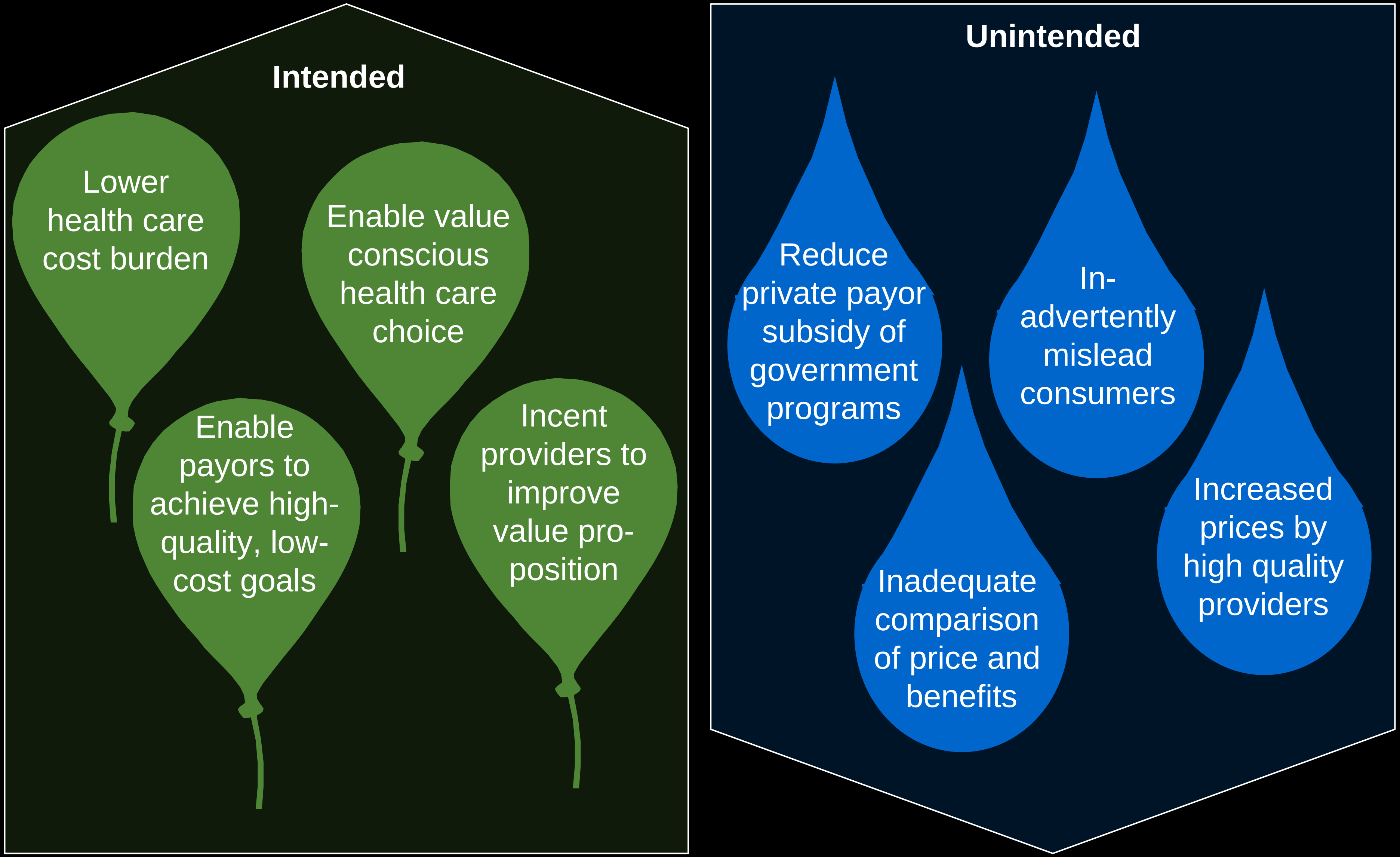
1 PRICE TRANSPARENCY COULD HAVE BOTH INTENDED AND UNINTENDED EFFECTS IN HEALTH CARE



Source: Team analysis

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1 IN VIRGINIA, OPPORTUNITY TO IMPROVE PREVENTION AND WELLNESS PERFORMANCE . . .

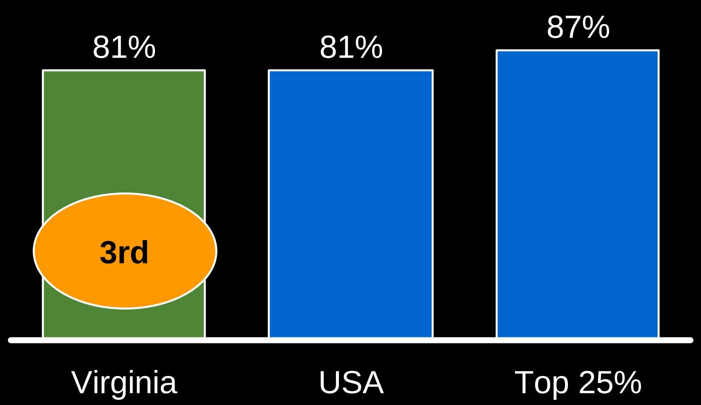
Virginia's quartile

Immunization

2004/2005, percent of at-risk populations receiving vaccine

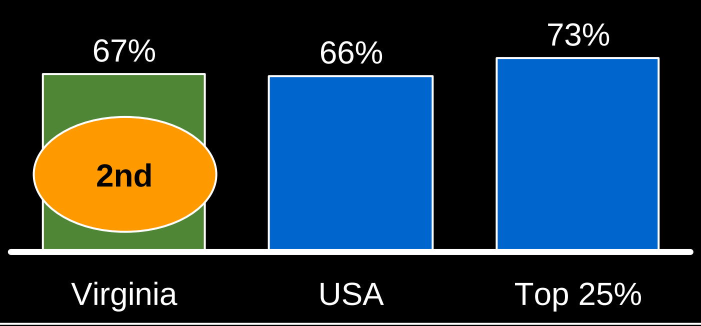
Children

19-35 months



Flu

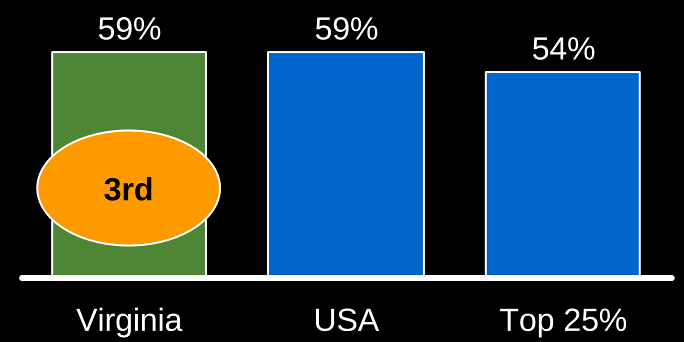
Age 65+



Population habits

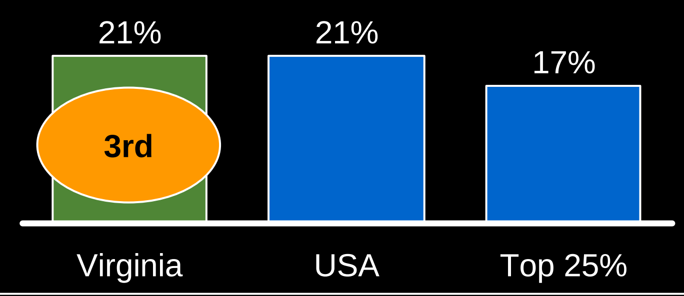
Obesity

Percent of the population obese



Tobacco

Percent of the population smoking



Source: CDC National Immunization Survey; CDC; team analysis

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1 . . . AND OPPORTUNITY TO IMPROVE OUTCOMES

2004/2005

	Cancer prevalence Cases per 100,000	Cancer death rate Deaths per 100,000	Diabetes prevalence Cases per 100,000	Diabetes death rate Deaths per 100,000
Virginia	456	199.1	6.2	22.8
U.S. average	462	193.5	6.7	25.3
1st quartile average	422	172.3	5.2	19.6
2nd quartile average	457	189.7	5.9	24.3
3rd quartile average	475	200.3	6.8	37.4
4th quartile average	500	214.6	7.9	32.2
Virginia's quartile	2nd	3rd	2nd	2nd
Virginia's rank	16th	29th	25th	14th

Source: American Cancer Society; NCHS

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1 KEY QUESTIONS TO CONSIDER

- What are the most important areas of quality improvement that you want to see?
- What type of information transparency will lead to the biggest changes in the market that you want?
- How can you mitigate the unintended effects of information transparency?
- How can you align payors, physicians, and providers to collaborate and cooperate to support transparency and quality improvement?
- What is driving Virginia's current performance?

Source: Team analysis

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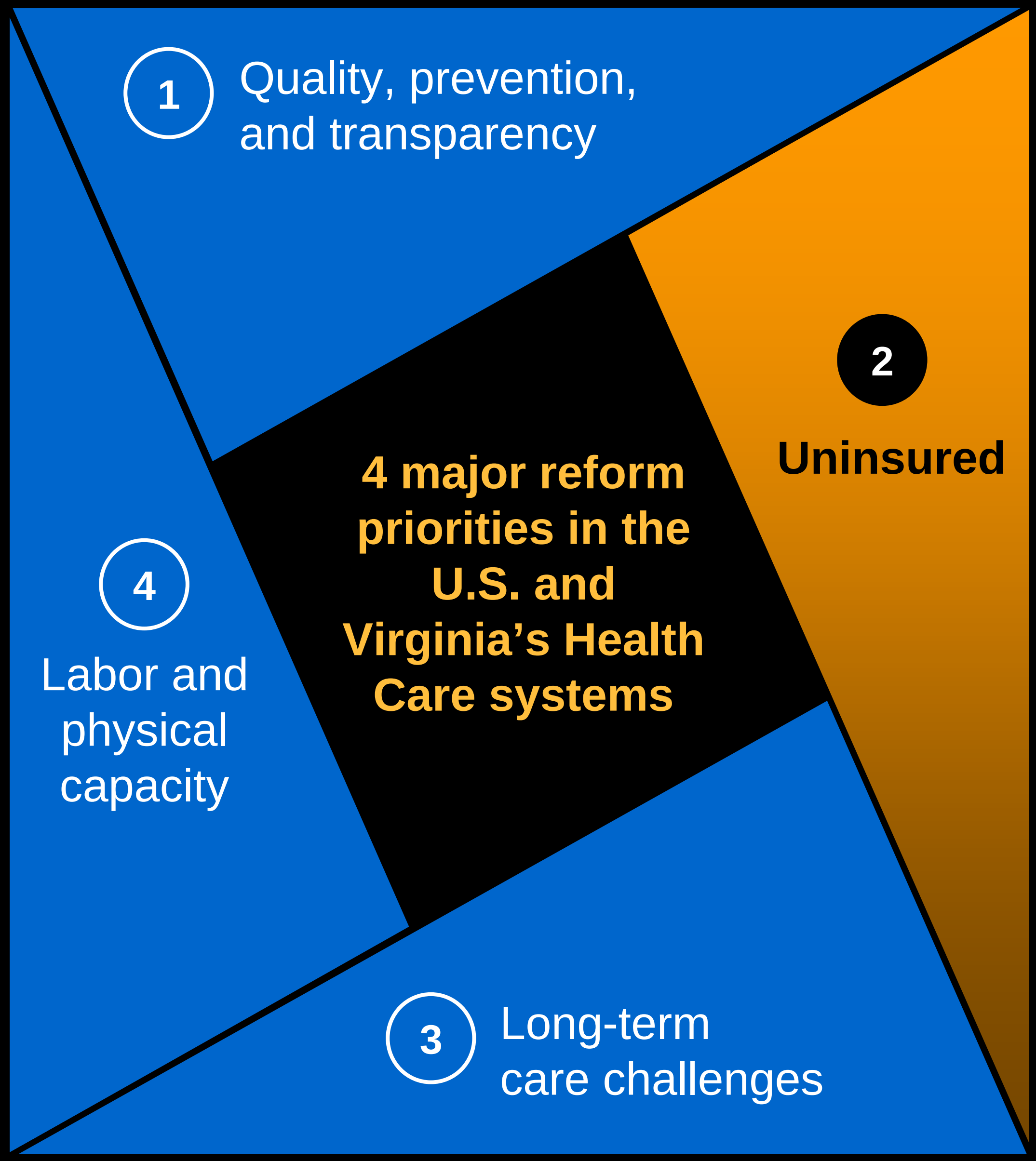
VIRGINIA REFORM PRIORITIES



2 THE UNINSURED

Main messages for the U.S.

- The **uninsured** population in the U.S. (16%) is **larger than in any developed OECD country**
- **The uninsured are growing**, due to rising costs of coverage driving employers and consumers to forego coverage
- Uninsured patients result in **cross subsidization of providers** to offset the cost of delivering care
- Uninsured patients have **worse access to care and poorer outcomes**

Main messages for Virginia

- Virginia has 14% uninsured and lies in the **3rd quartile**, when compared to all other states
- **~30% of the uninsured** in Virginia have **income above the state average** (40% if we consider the U.S. average income)
- Success with the **FAMIS program** now covering 99.5% of children who qualify for the program

Source: Team analysis

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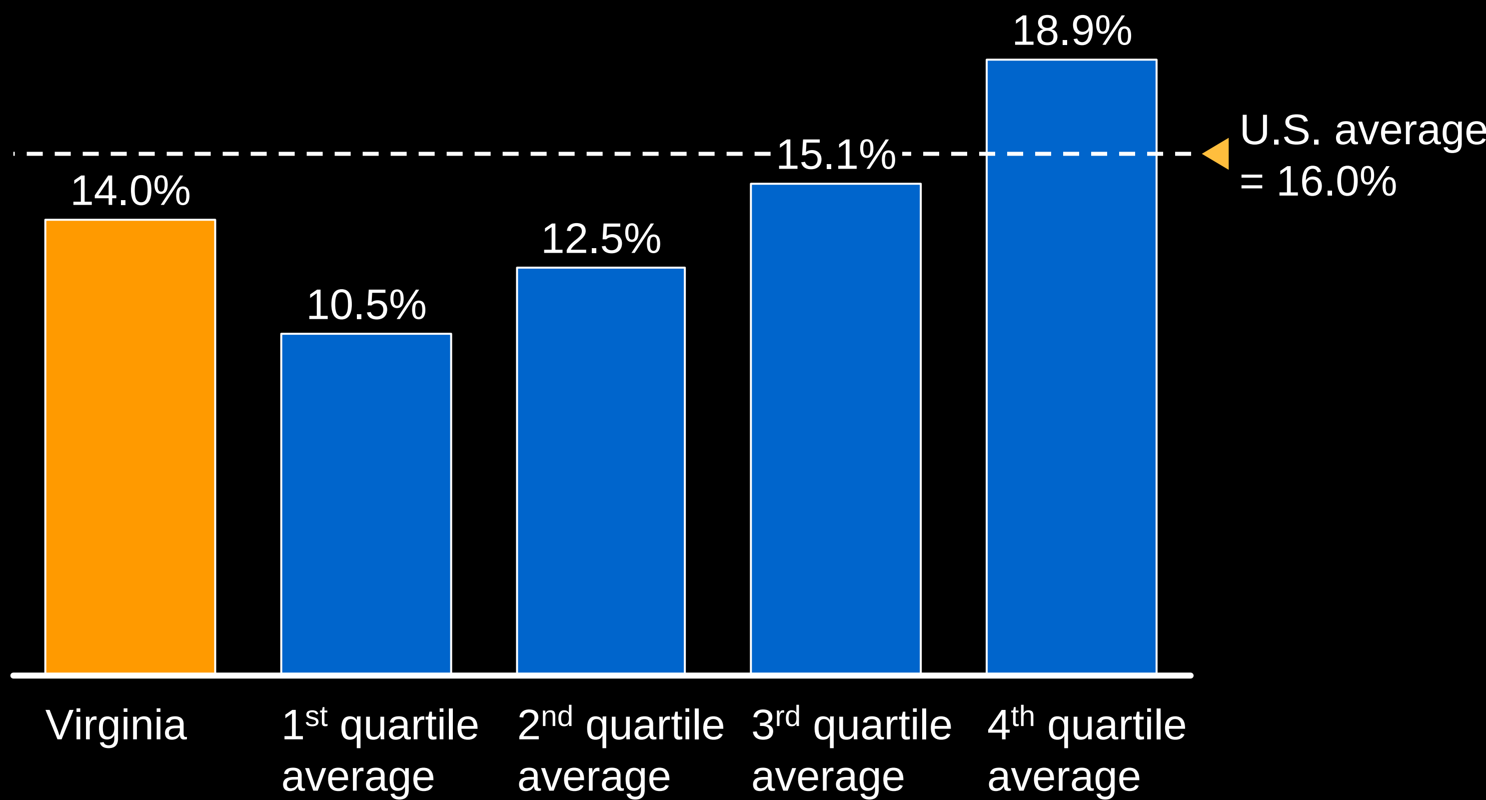
2 WHILE VIRGINIA'S UNINSURED IS BELOW THE U.S. AVERAGE . . .

2004



- **Virginia is in the 3rd quartile and ranks 28th among all states**
- Rising costs of coverage reducing employer coverage
  - Uninsured who are employed rose from 53% in 2002 to 58% in 2005

Source: U.S. Census Current Population Survey; Kaiser Family Foundation

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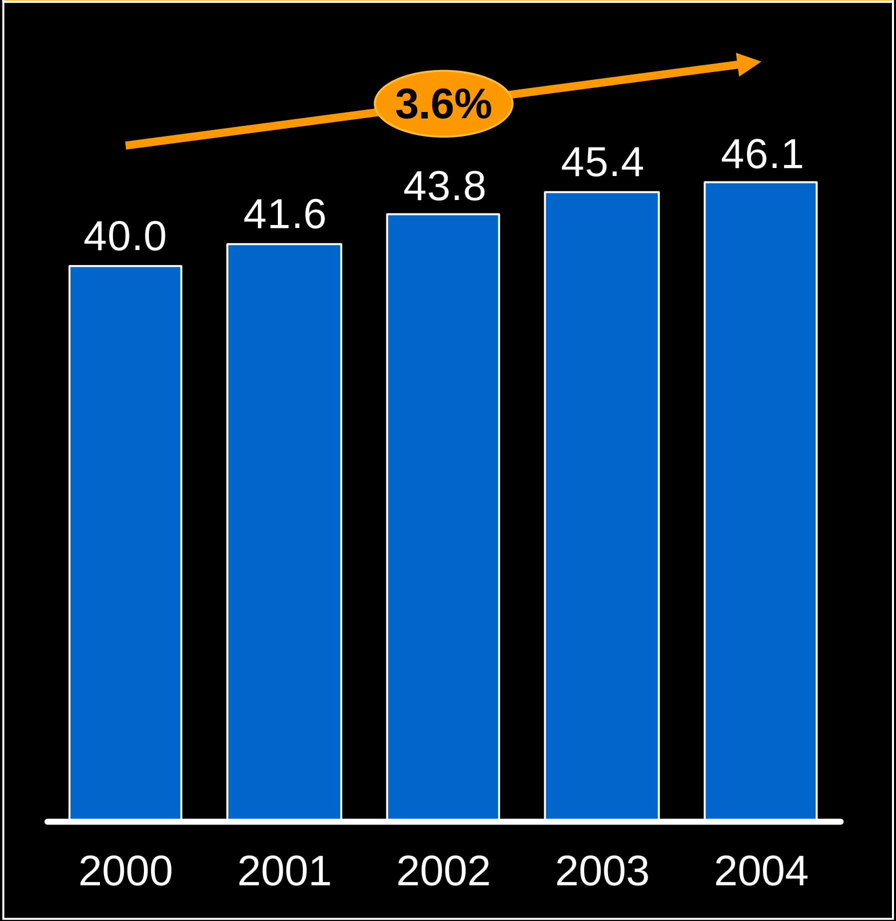
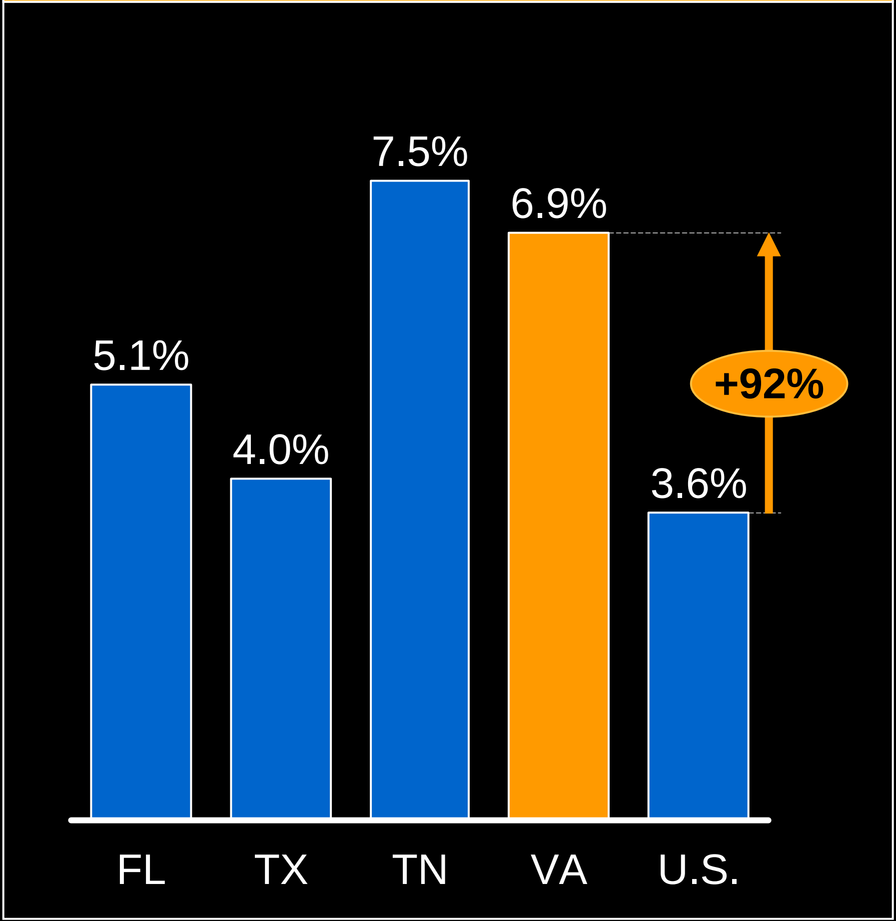
2 . . . THE NUMBER OF UNINSURED ARE GROWING IN THE U.S. AND MORE RAPIDLY IN VIRGINIA

U.S. uninsured
2000-2004, Millions



Uninsured growth rate in selected states
2000-2004



Source: Economy.com; Kaiser Family Foundation; team analysis

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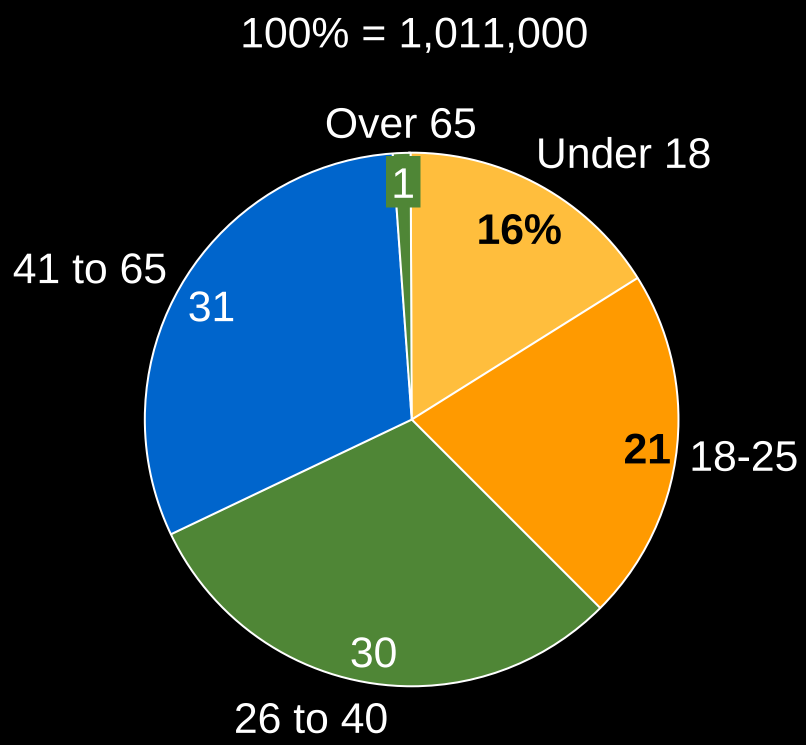
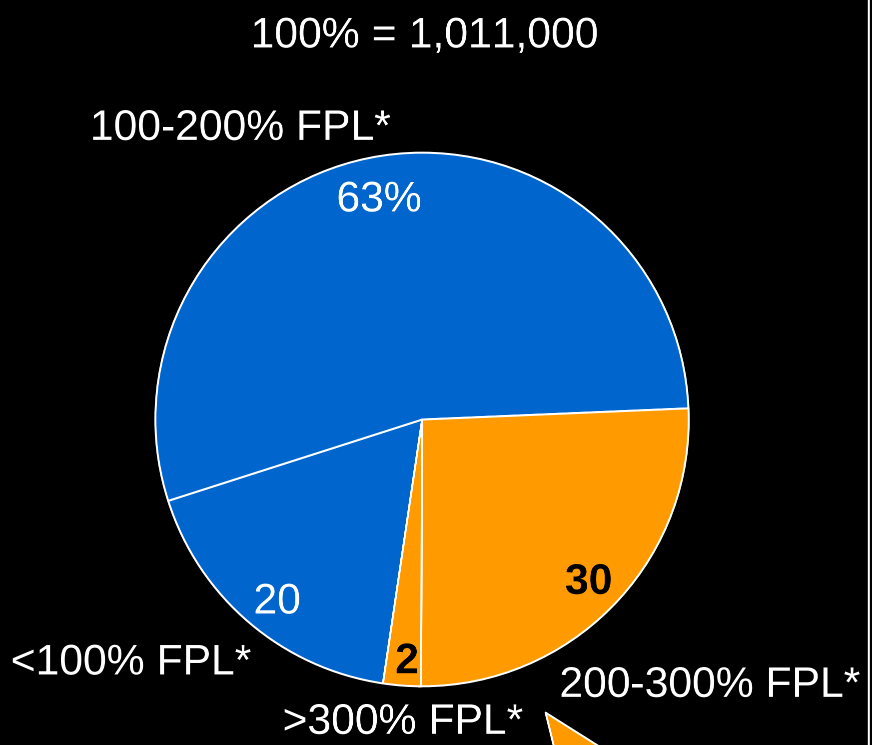
2 30% OF VIRGINIA'S UNINSURED HAVE INCOMES ABOVE THE STATE AVERAGE

ESTIMATES

Age distribution of Virginia's uninsured
Percent



Income distribution of Virginia's uninsured
Percent



Average income in Virginia is $54,000 per year

* Federal Poverty Line
Source: Current Population Survey (Census); team analysis

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2 KEY QUESTIONS TO CONSIDER

- What can the state do to make health insurance coverage more affordable?

- What can be done to deal with individuals who can afford coverage but choose to remain uninsured?

- What can be done to provide more coverage to working adults? to children under 18?

Source: Team analysis

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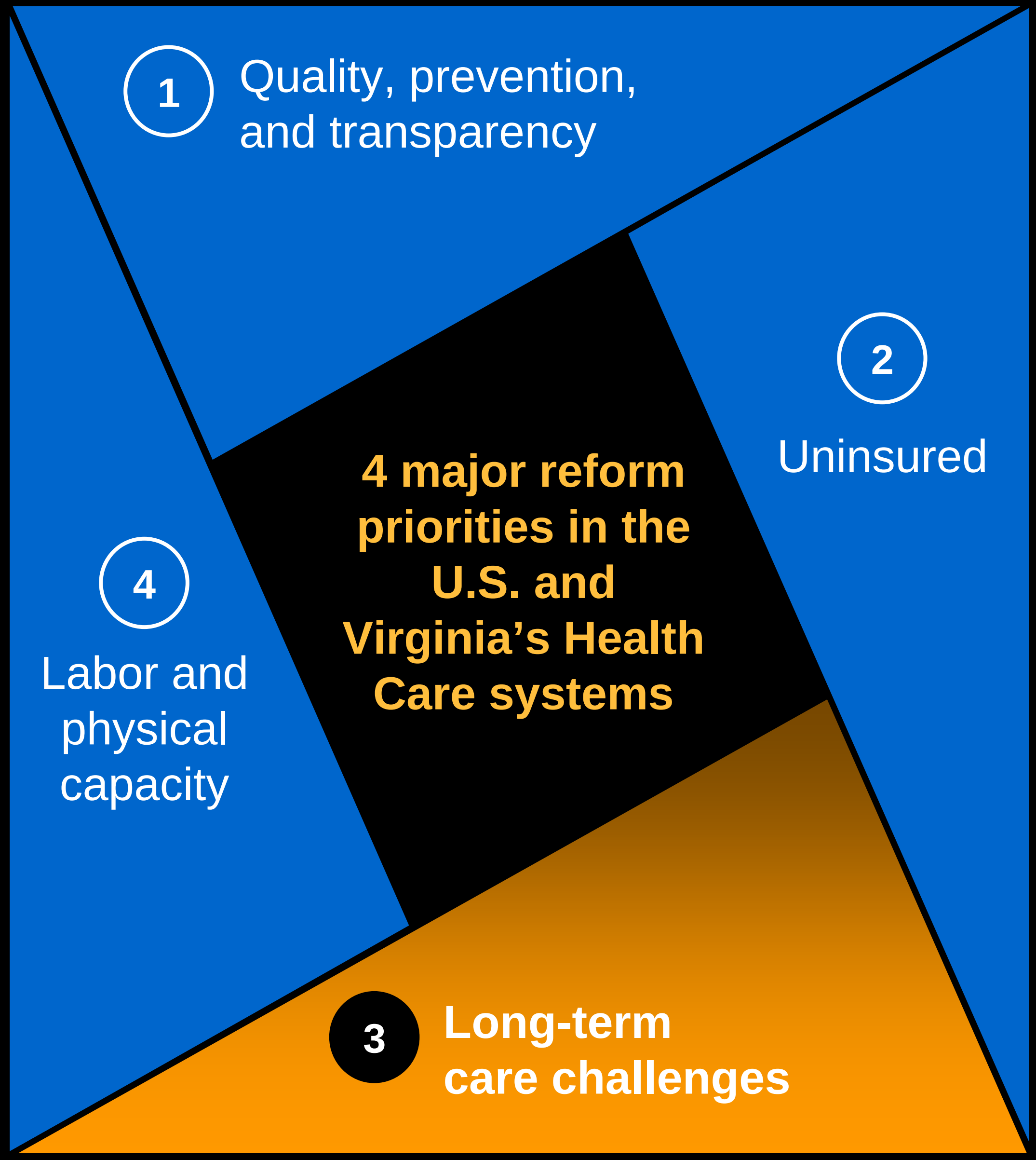

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3 MEDICAID LONG TERM CARE COSTS

Main messages for the U.S.

- Medicaid is the **largest payor**
- Medicaid **expenditures** are projected to **grow rapidly** in the coming years
- Aged and disabled drive the majority of costs
- If left unchanged, **Medicaid will consume a disproportionate share of state revenue growth**
- **All 50 states** employed some type of new Medicaid **cost containment strategy** in 2005

Main messages for Virginia

- Virginia **payments** for Medicaid are well **below the nation's average**
- **26% of all new tax revenues** are projected to be needed to fund growing Medicaid costs
- Medicaid **LTC** expenditures are **not growing as fast** as in other states
- Only **3% are covered** with private long term care insurance

Source: Team analysis

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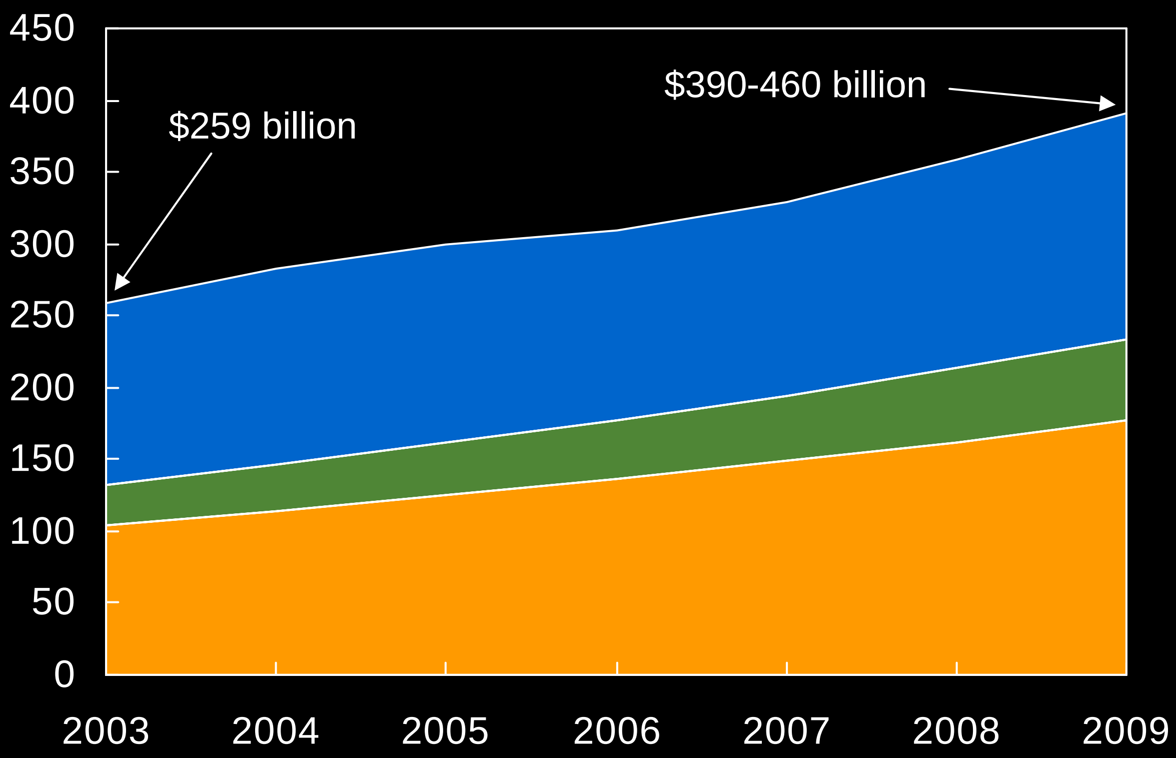
3 IN THE YEARS AHEAD, MEDICAID COSTS ARE PROJECTED TO GROW RAPIDLY

Medicaid cost projections (2003-2009)
$ Billions



CAGR (2003-'09)

Medicaid overall 7-9%

Other – professional
- Inpatient
- Outpatient

Pharmaceuticals** 13%

Long-term care 9%
- Institutional services
- Home health care
- Community-based services

$102	$113	$130	$144	$159	$175	$189	**Disabled population***** 10%

* Based on overall Medicaid growth rate of 7%

** May not capture pharmaceutical spend which is embedded in other cost categories (e.g., MCO payments)

*** The rate of cost growth for this population is related to the cost trends for pharmaceuticals and long-term care, since the disabled population is a heavy user of these services (e.g., in 2002, ~45% of the cost for the disabled population was for long-term care services)

Source: CBO 2004 baseline; CMS National Health Care Expenditures Projections (2002-12); McKinsey analysis

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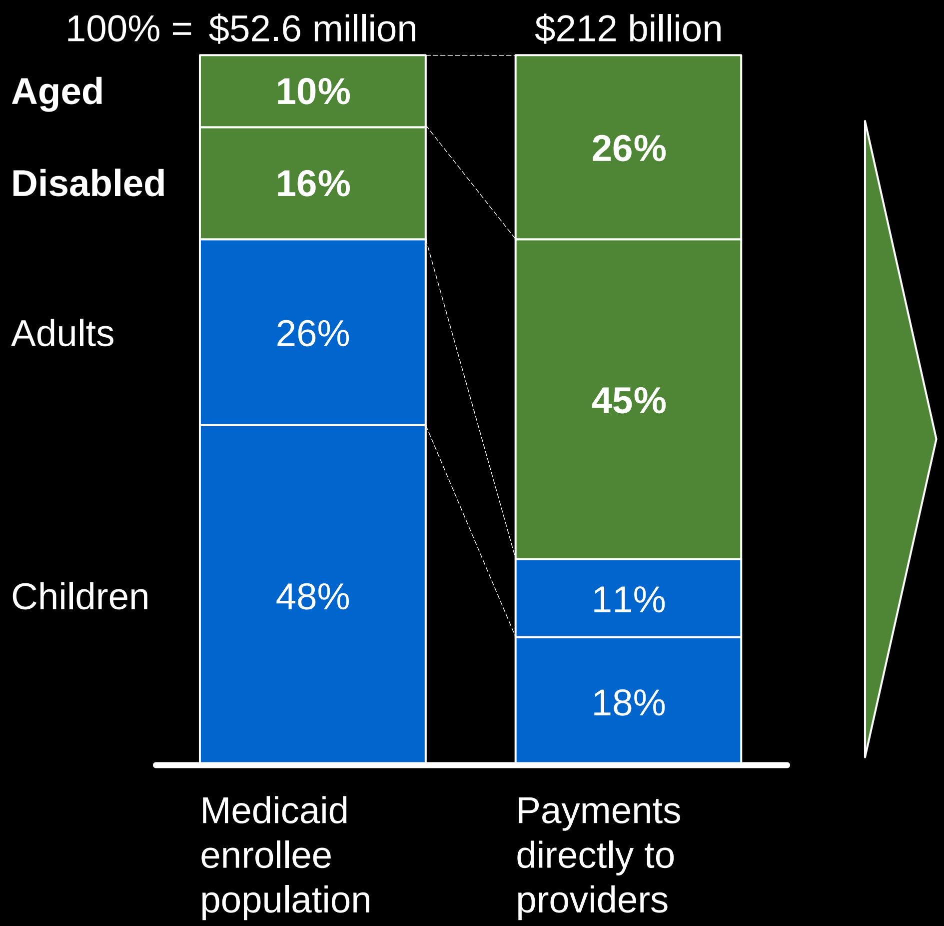
3 THE AGED AND DISABLED DRIVE THE MAJORITY OF COSTS

U.S. Medicaid population and spend breakdown
FY2004



- Less than 30% of the population accounts for over 70% of Medicaid outlays to providers
- Those driving costs are not typically covered by managed care organizations
- These populations tend to persist longer in Medicaid because of their significant health needs (e.g., ~40% retention rate in Medicaid vs. ~10% for comparable population in commercial health insurance

Source: Kaiser Commission on Medicaid and the Uninsured; CMS; CBO; McKinsey analysis

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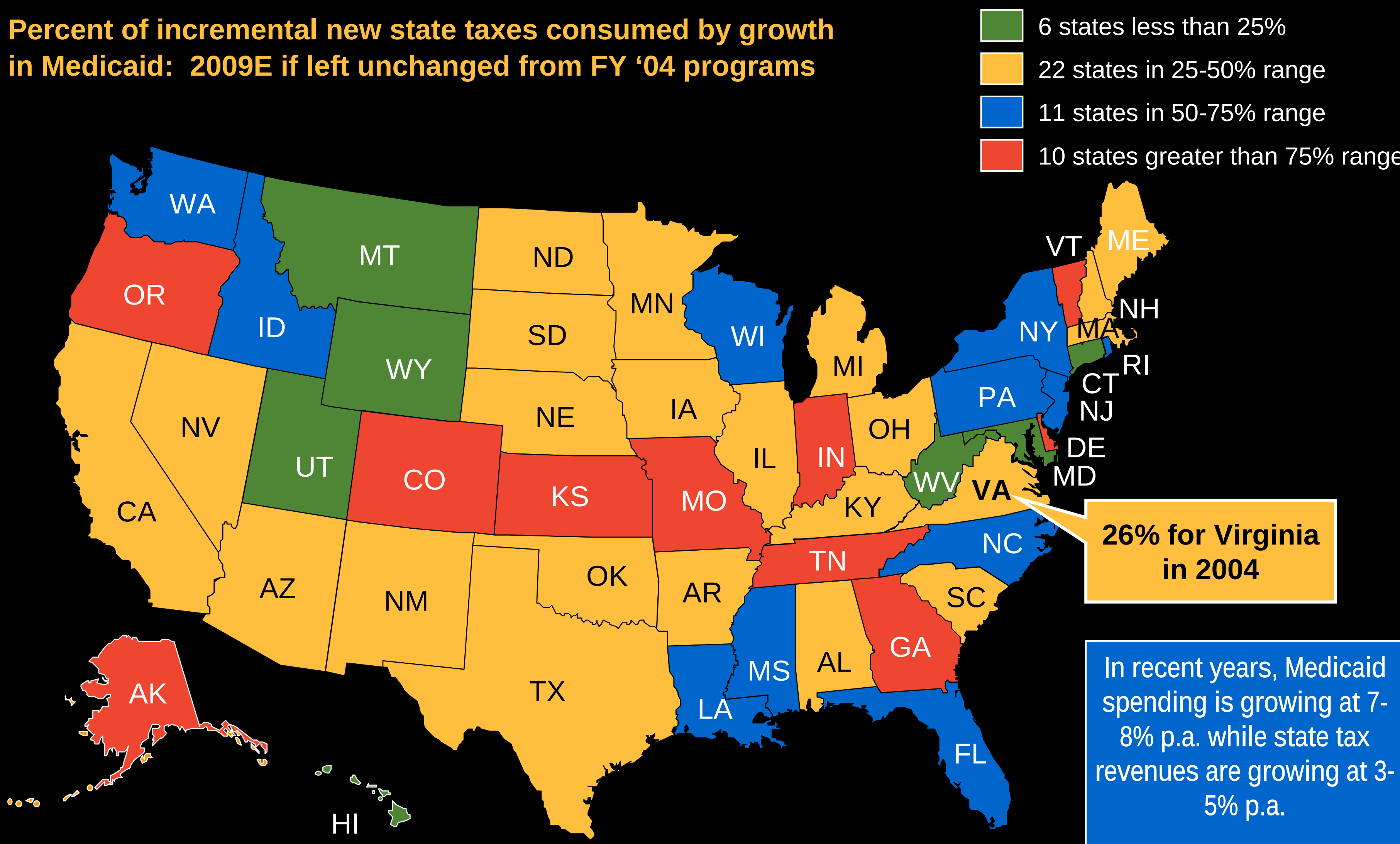
3 IF LEFT UNCHANGED MEDICAID WILL CONSUME A DISPROPORTIONATE SHARE OF STATE REVENUE GROWTH

Percent of incremental new state taxes consumed by growth in Medicaid: 2009E if left unchanged from FY '04 programs



In recent years, Medicaid spending is growing at 7-8% p.a. while state tax revenues are growing at 3-5% p.a.

Source: CMS; Bureau of Census; BEA; CBO; NASBO; Literature search; McKinsey analysis

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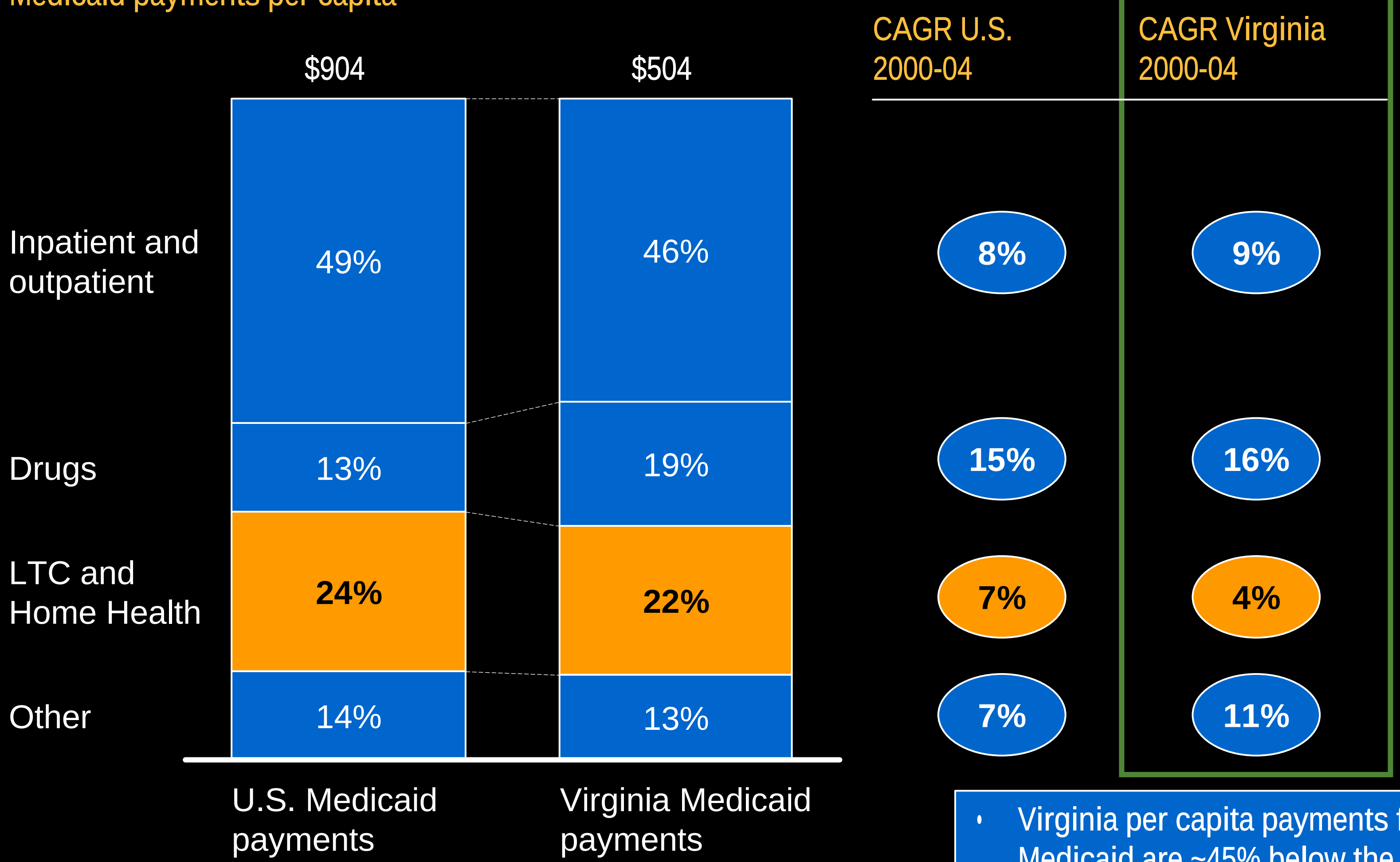
3 VIRGINIA SPENDS FAR LESS THAN THE NATIONAL AVERAGE ON MEDICAID

U.S. Dollars, 2004

Medicaid payments per capita



- Virginia per capita payments for Medicaid are ~45% below the national average
- LTC expenditures are not growing as fast as in other states

Source: NHE; McKinsey analysis

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3 KEY QUESTIONS TO CONSIDER

- Why are LTC costs not growing as fast in Virginia than other States?
  - Will this trend continue or will Virginia catch-up?
  - How does quality of LTC compare to other States?

- How can incentives be aligned among patients, LTC providers, hospitals, and physicians to manage/optimize total cost of care?

Source: Team analysis

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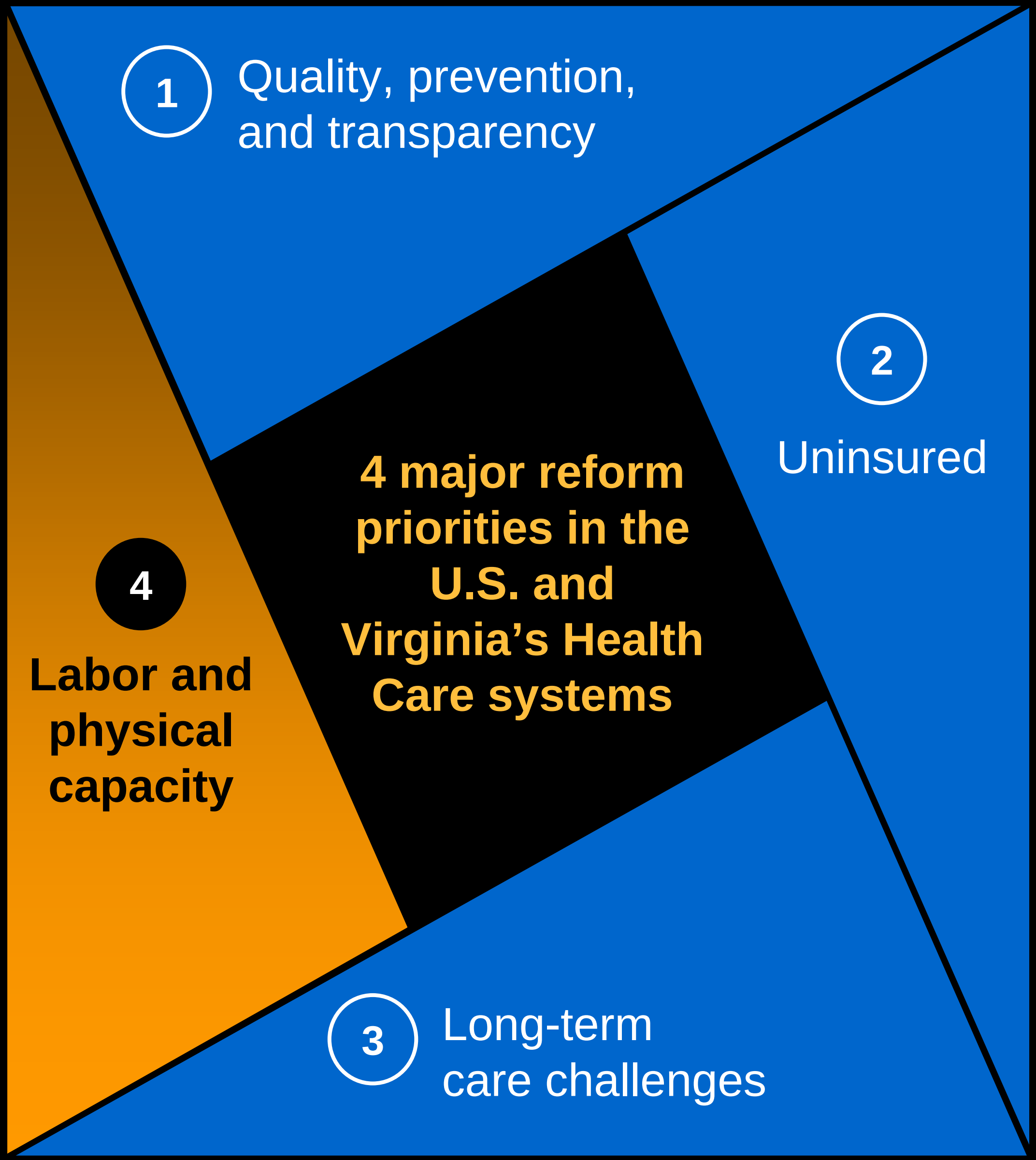

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4 LABOR AND PHYSICAL CAPACITY

Main messages for the U.S.

- **No shortage of physicians** if compared to peer countries, however physicians in the U.S. perform more consultations
- **More nurses** and clinical labor is staffed in hospitals and outpatient centers than in peer countries
- **Overcapacity** in **hospital** beds and **outpatient** surgery and imaging centers

Main messages for Virginia

- **Physician** and **nurse** workforce is **slightly below nation's average**
- **Sub-optimal distribution** of physicians and nurses
- **Below anticipated number of hospital beds** based on the number of inpatient days

Source: Team analysis

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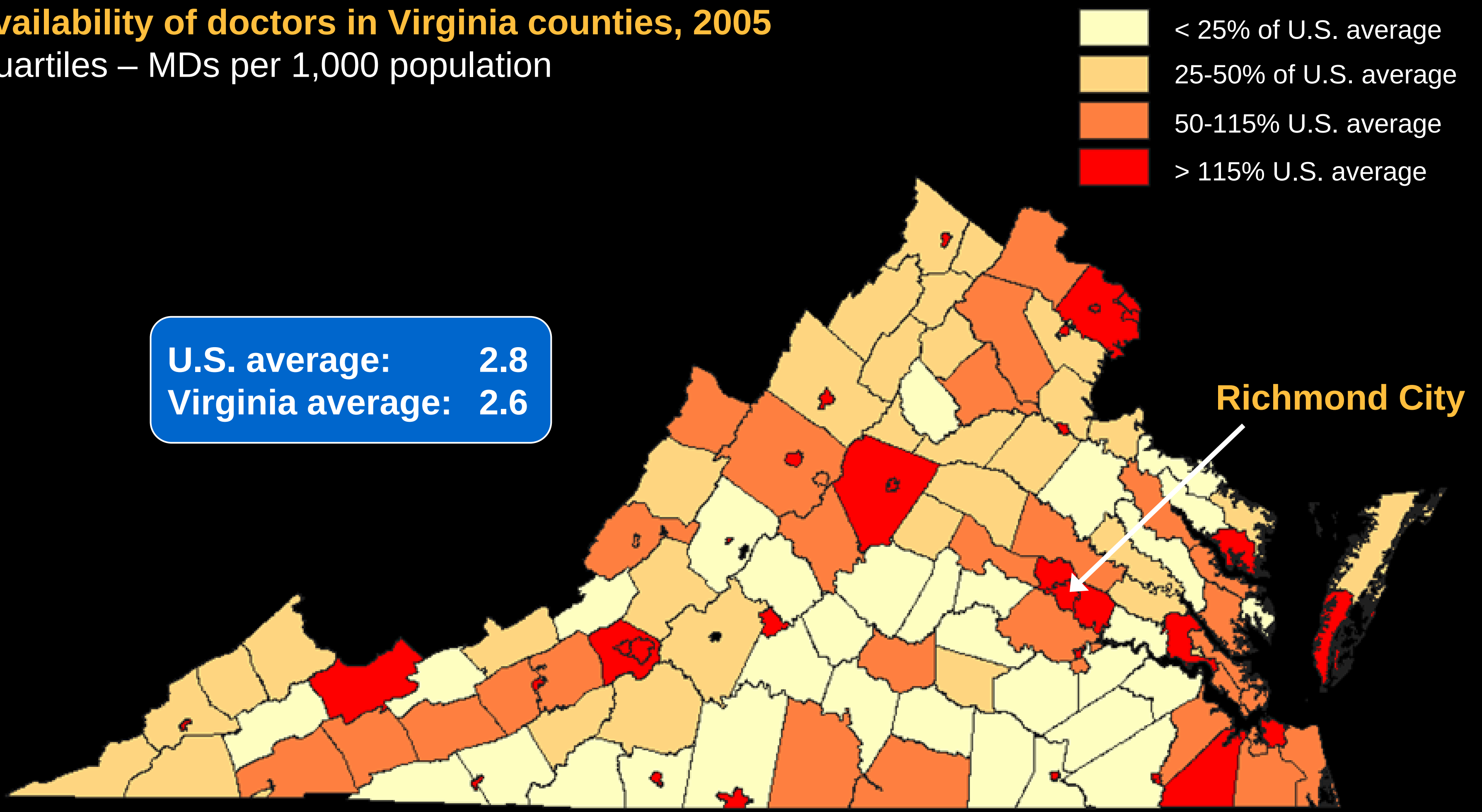
4 DISTRIBUTION OF PHYSICIANS INDICATES MISMATCH OF POPULATION AND PHYSICIANS . . .

Availability of doctors in Virginia counties, 2005

Quartiles – MDs per 1,000 population

U.S. average:	**2.8**
Virginia average:	**2.6**



Source: ESRI Demographic estimates; Maptitude; Virginia Dept. of Health Professions

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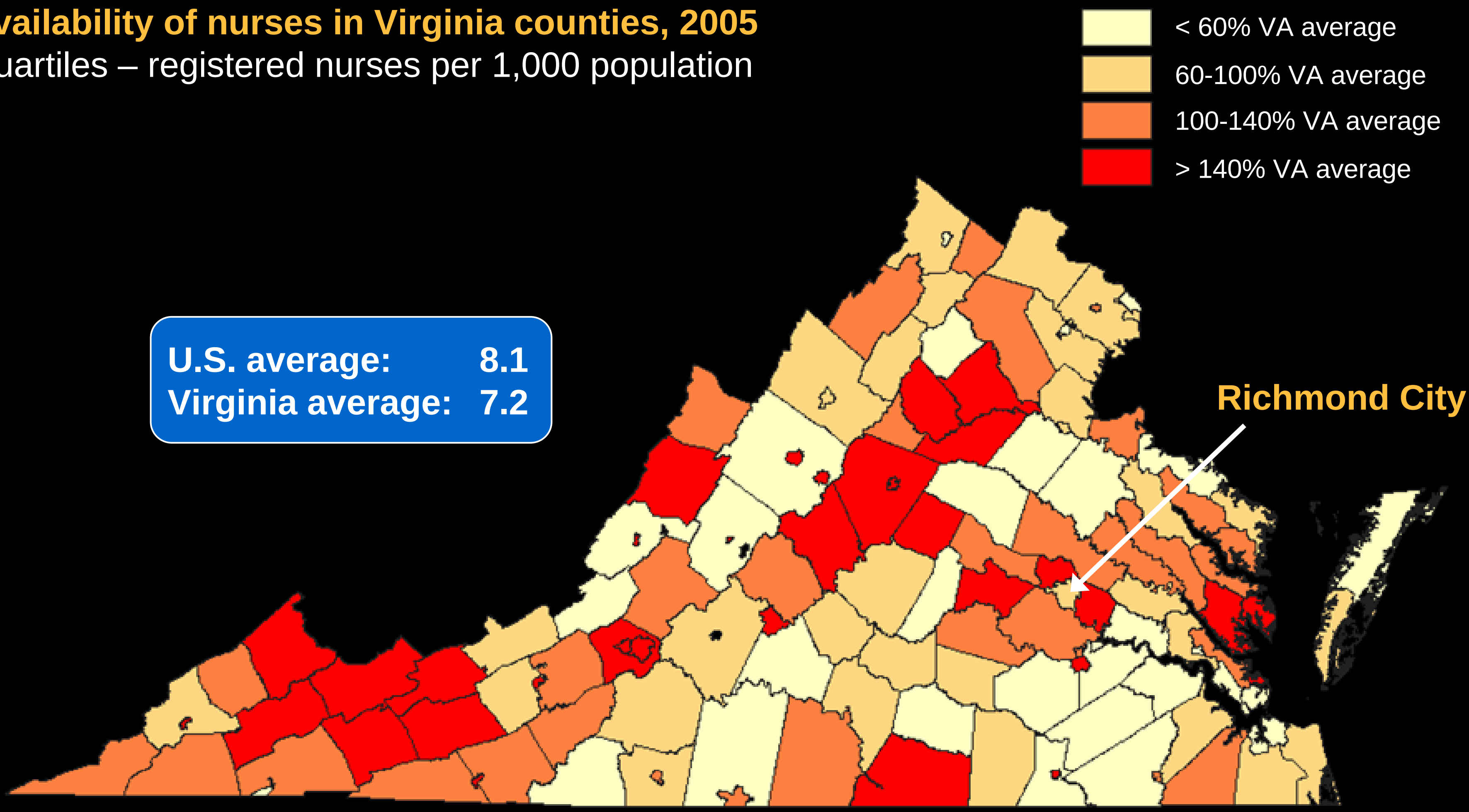
4 . . . SIMILAR GEOGRAPHIC MISMATCH FOR NURSES

Availability of nurses in Virginia counties, 2005
Quartiles – registered nurses per 1,000 population



Source: BLS, ESRI Demographic estimates; Maptitude; Virginia Dept. of Health Professions, team analysis

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4 INCREASE IN NURSING SCHOOL ENROLLMENT WILL HELP DRIVE DECLINE IN WAGE GROWTH

Nursing enrollment is rising nationally
Percent change from previous year

To benefit from rising national interest in nursing, Virginia will need:

- Attractive pool of candidates
- Capacity to train them
- Funding to support programs

* Index representing private hospital salary costs

Source: Economy.com; Bear Stearns; BLS

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4 KEY QUESTIONS TO CONSIDER

- Is their existing capacity to train more nurses and physicians in Virginia?
- What are the trade-off of training more nurses and physicians in Virginia versus attracting talented labor from elsewhere?
- What incentives are required to address geographic mismatch of labor?

Source: Team analysis

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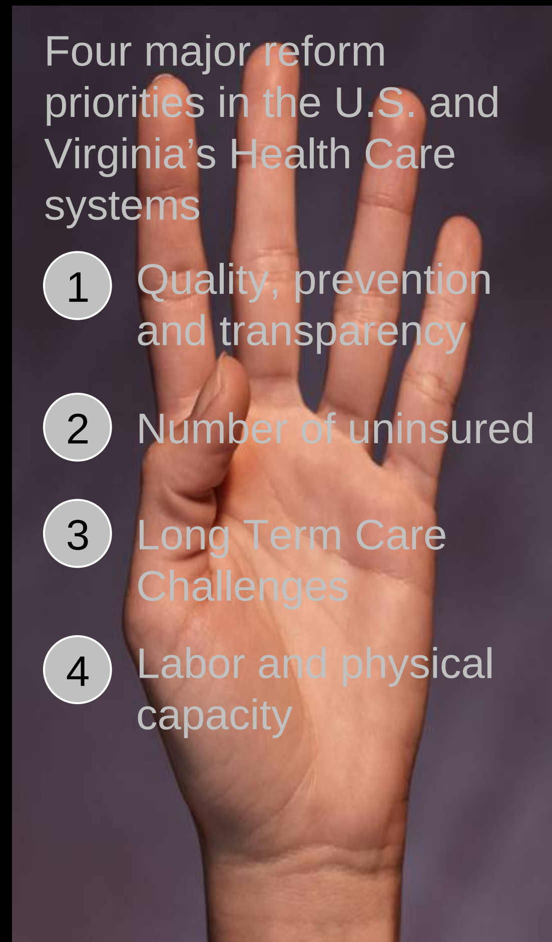
TOPICS FOR TODAY’S DISCUSSION



FRAMEWORK TO GUIDE THE REFORM OF HEALTH CARE SYSTEMS

What levers must a **health care system leader or intermediary** follow to promote equity, quality, cost effectiveness, and service sustainably

- Actively manage **demand** for health care products and services
- Ensure that the **supply** of health care matches the quantity, price and quality demanded by the market

Design levers

1. Prevent illness and injury
2. Ensure value-conscious consumption
6. Promote sustainable financing mechanisms to collect and distribute funds
3. Promote efficient creation of capacity for labor, infrastructure, and innovation
4. Promote improvements to safeguarding and to service levels
5. Promote improvements to cost competitiveness

7. Provide adequate organizational framework and deploy adequate approaches to allow the implementation of strategy levers

Source: MGI analysis

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IMPLEMENTATION APPROACHES TO SHAPE DEMAND AND SUPPLY

EXAMPLES

Contextual — Indirect — Direct

	Awareness	Incentives	Mandates	Direct action
Prevention	• Educate public on diet, exercise, smoking, safe sex	• Contribute to HSAs based on lifestyle changes	• Restrict air pollution that is harmful to the public health	• Create public water and sewage systems
Value consciousness	• Publish hospital quality metrics on the internet	• Tier benefit designs to encourage use of select providers	• Exclude coverage for high-cost providers or procedures	• N/A
Capacity	• Conduct public needs assessments to inform private investment	• Forgive loans for physicians practicing in underserved areas	• Require regulatory approval based on demonstration of need	• Build public hospital in underserved communities
Quality, safety and service	• Publish guidelines for evidence-based medicine	• Pay bonuses to providers for implementing EBM	• License/credential providers based on minimum standards	• Improve the quality of publicly run hospitals
Cost competitiveness	• Document and disseminate best practices in lean ops	• Negotiate preferred vendor agreements with low-cost providers	• Impose standard pricing for all MDs, set at low level to drive cost reductions	• Increase the efficiency of publicly run hospitals
Financing	• Educate consumers about the need to save for long-term care	• Offer tax subsidy for purchase of employer-sponsored coverage	• Mandate insurance coverage for all not covered by public entitlement program	• Offer tax-financed entitlement program

Source: MGI analysis

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FUNDAMENTAL QUESTIONS FOR REFORMERS

Demand

- How can the Virginia influence and shape future demand for healthcare?
- What is the most effective financing and payment approach?
- Are consumers willing to make value trade-offs as information becomes more transparent?

Supply

- How do you promote innovation that decreases cost and improves quality?
- What is the optimal approach for managing capacity since incremental capacity can generate new demand?
- Are stakeholders willing to let excess capacity come offline?

Intermediation

- What are the lessons (successes and failures) from other State reform programs?
- What type of reforms have had the most impact?

Source: Team analysis

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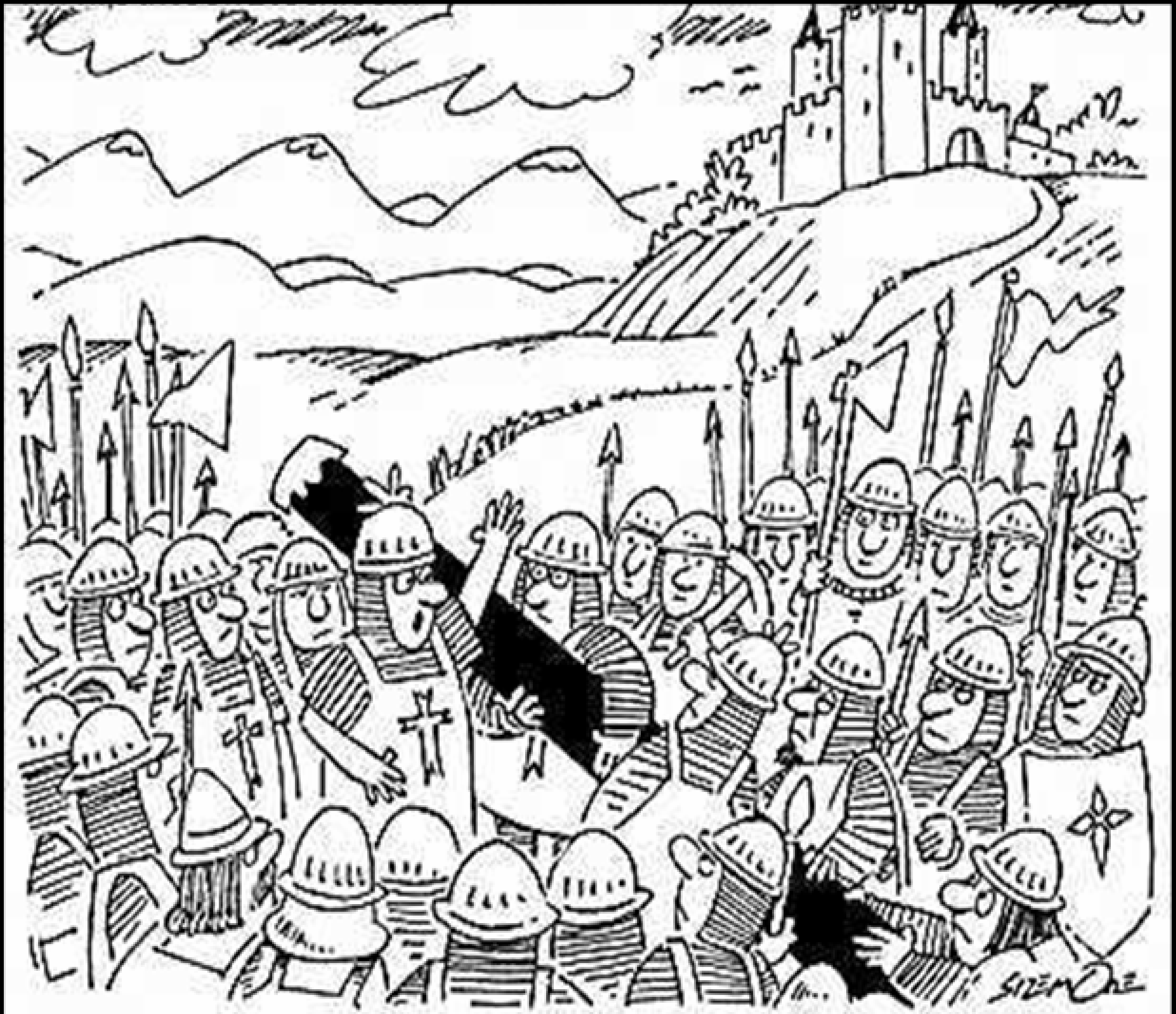
THANK YOU



"Look, if this fails we'll still have to do business with them, so try to be subtle about it."